

Adverse Selection and Encouraging Market Competition and Value

Minnesota Health Insurance Exchange Advisory Task Force

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Overview

- Work group background
- What is adverse selection?
- Why is adverse selection important for Exchanges?
- Tools to mitigate adverse selection
- ACA adverse selection provisions
- Adverse selection concerns
- Initial issues addressed by work group
- Next steps

What is Adverse Selection?

- **What is adverse selection?**
 - The separation of healthy and less healthy people into different insurance arrangements.
 - The tendency of less healthy populations to seek coverage.
- **When does adverse selection occur?**
 - When a health benefit plan product or group of products enroll a greater proportion of individuals with higher than expected health care costs.

Why is Adverse Selection Important?

- **Why is adverse selection an issue for Exchanges?**
 - Separation of risk can result in higher risk, higher premiums, and lower enrollment inside vs outside a product/market/pool that continues over time (death spiral).
 - Example: Purchasing pools enacted by many States in the 1990s (voluntary participation and different market rules and products)
 - If premiums increase beyond budget neutrality, ACA subsidies could be reduced and negatively impact affordability into the future

Tools to Minimize Adverse Selection

- Medical Underwriting
- Pre-existing Exclusions
- Waiting Periods
- Mandatory Purchase
- Open Enrollment Periods
- Late Enrollment Penalties

ACA Adverse Selection Provisions

- **ACA provisions to mitigate adverse selection with Exchanges:**
 - Minimum benefit level
 - Same benefit rules (metal levels) inside and outside Exchange
 - Same rating/underwriting rules inside and outside Exchange
 - Exchange subsidies
 - Same premium for same products offered inside and outside Exchange
 - Single risk pool inside and outside Exchange
 - Risk adjustment inside and outside Exchange

Adverse Selection Concerns

- **Adverse selection concerns for states and Exchanges:**
 - Different rules inside and outside Exchange related to certification and open enrollment
 - Different insurers and products participating inside and outside Exchange
 - Self-funding by small employers
 - Association plans
 - Defined contribution/employee choice and market merger
 - Risk adjustment incentives and accuracy
 - Participation rules for individuals and small employers

Initial Issues Addressed by Work Group

- Should the market rules for health plan certification be consistent inside and outside the Exchange?
- Should participation by insurers and health benefit plan products be the same or different inside and outside the Exchange?
- Should the definition of small group be increased from a maximum of 50 to a maximum of 100 in 2014 before this change is required in 2016?
- Should Minnesota defer to a federal risk adjustment model or propose a state risk adjustment model?
- Should the individual and small group market risk pools be merged?

Exchange Plan Certification Rules

- Marketing criteria
- Network adequacy requirements
- Accreditation on local clinical quality measures, patient experience, consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, and patient information systems
- Disclosure of information on claims payment policies, claims denials, data on enrollment and disenrollment, rating practices, cost-sharing for in network and out of network providers, and company financial information
- Implementation of a quality improvement strategy
- Health plan offering of at least 1 “Silver” and 1 “Gold” plan
- Comply with open enrollment provisions

Consistency of Market Rules

Pros

- Unlevel playing field provides incentives for consumer and employer adverse selection and gaming by insurers
- Experience demonstrates different rules lead to adverse selection and premium death spiral
- Risk adjustment may be difficult if market rules are different
- Avoids consumer /employer confusion

Cons

- If rules are too stringent, consistent rules could limit innovation, product development and participation in market

Different Insurer and Health Benefit Plan Participation

Pros

- Consumers may be overwhelmed by too many choices
- Limiting choices/negotiating choices may incent insurer competition
- Limiting choices could ensure access to more comprehensive coverage
- Could ensure that innovation is not limited in the market
- Administrative cost differences may drive competition on efficiency

Cons

- Consumers have different needs - limiting choice may be viewed as discriminatory
- Limiting choices to more comprehensive coverage may make choices unaffordable to unsubsidized consumers and employers/employees – especially under defined contribution
- May incent consumer/ employer adverse selection and insurer gaming
- Incent competition between Exchange and outside market instead of between insurers
- May encourage more innovation outside Exchange
- Limits portability and longer term care management

Increasing Small Group Size to 100 Prior to 2016

Pros

- Larger risk pools could create more stable premiums
- Implementing change now with other market changes will avoid prolonging impact
- May help 51-100 market get more stable premium rates
- Modeling shows that risk mix between the two employer size groups is similar

Cons

- Adds another level of uncertainty to changing market
- Healthier 51-100 groups may see premium increases and opt to self-insure or drop coverage
- No significant impact on either market premium, so no clear advantage to increasing the size early given potential impact of some self-insuring

Risk Adjustment

- **What is risk adjustment?:** The process of adjusting payments to organizations/insurers based on differences in the risk characteristics or health status of people enrolled.
- **Why is it needed?:** In a community rated and guarantee issue environment where premiums do not fully reflect the relative costs of healthy and sick individuals, insurers have the financial incentive to compete for healthy individuals rather than compete on efficiency, quality, and value.
- **State option:** Federal government will establish and operate method for risk adjustment for individual and small group plans inside and outside Exchange. States with claims databases may propose alternate mechanism.

Risk Adjustment

- **General goals of risk adjustment:**
 - Maximize accuracy
 - Limit incentive for insurers to avoid risk/sicker individuals
 - Create incentive for insurers to effectively manage sicker individuals
 - Minimize gaming or upcoding
 - Protect the solvency of insurers through fair and equitable compensation for assumed and managed risk

General Risk Adjustment Methods

- **Prospective:** Use of historical health data to determine risk-adjusted payments in a subsequent period.
 - Accurate assessment of predictable risk, but less accurate than concurrent
 - More resistant to gaming/upcoding
 - Greater incentive to manage care for higher risk individuals
- **Concurrent/Retrospective:** Use of current health data for current risk-adjusted payments. Generally requires retrospective payment reconciliation.
 - More accurate assessment of predictable and unpredictable risk than prospective
 - Less resistant to gaming/upcoding
 - Less incentive to effectively manage care for higher risk individuals, but better than typical reinsurance mechanisms

Proposed Risk Adjustment Rules

- **Federal Methodology:**
 - Similar to Medicare
 - Will collect and use claims data for calculations
 - Concurrent/retrospective method (at least initially)
- **State Option:**
 - States can perform risk adjustment
 - Must have all payer claims database to conduct risk adjustment
 - Must submit state option/methodology to federal government by November 2012 for consideration

Option for State Risk Adjustment Model

Pros

- Would allow for immediate 2014 prospective model
- Flexibility to incorporate risk experience of Medicaid enrollees
- Would move money more quickly between insurers
- More flexible and tailored to Minnesota-specific issues, such as geographic differences
- May garner more confidence from insurers and result in more stable premiums
- Less administrative costs for insurers compared to submitting data twice to state and federal governments

Cons

- On-going cost of doing risk adjustment at state level
- Time and resources to develop state risk adjustment model

Market Merger

- PPACA gives states the option of merging their individual and small group markets
- 2014 changes in the market to consider:
 - Benefit and rating rules for both markets will be the same
 - New and sizeable populations will be added to the individual market (uninsured, MCHA, and some public program enrollees)
 - Individual and small group markets will become similar in size

Market Merger of Individual and Small Group Market Risk Pools

Pros

- Creates larger, more stable risk pool
- Larger risk pool may encourage new insurers to enter market
- Modeling shows minimal impact to premiums in either market
- With defined contribution, markets may naturally merge over time
- If not merged, small groups may adversely select market under defined contribution
- May be easier to risk adjust, especially with defined contribution/employee choice
- Potentially reduces administrative costs for insurers over time

Cons

- Creates additional uncertainty for premium rating
- May discourage small group participation if premiums increase
- Could discourage insurers from offering coverage if they don't want to offer coverage for individual and small group
- Reinsurance impact would be diluted for 2014-2016 time period
- Can always do in future; once merged, hard to separate if negative impacts and may be hard to identify issues
- May be initial administrative costs and challenges to merging markets